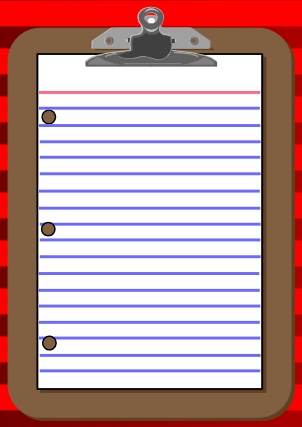
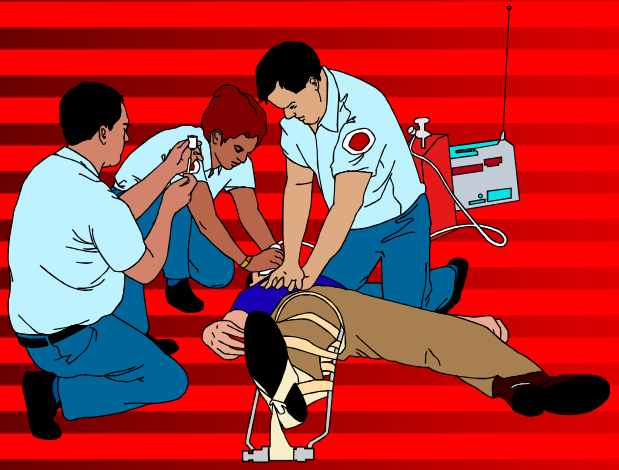
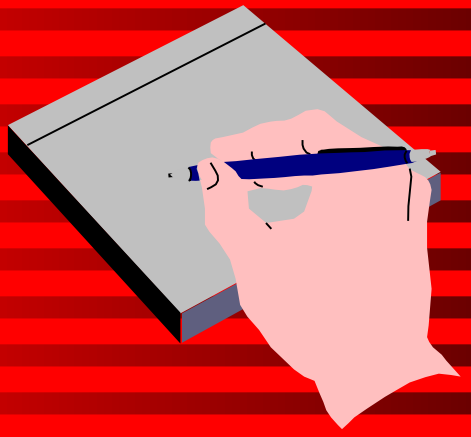


DOCUMENTATION





Lesson Objective

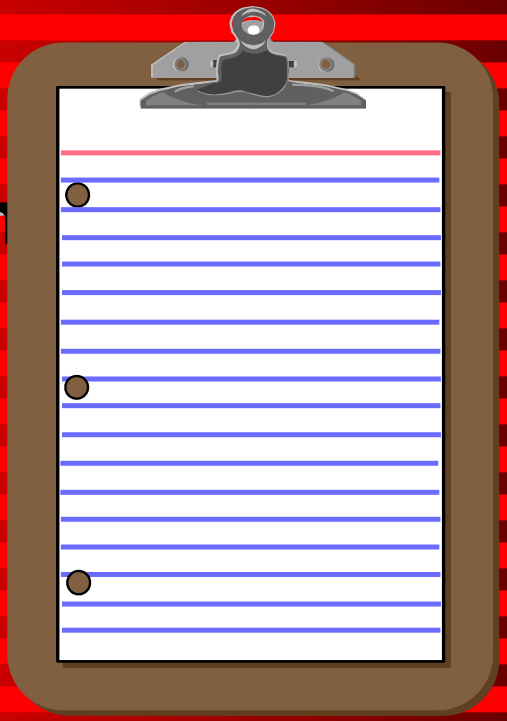
- **Identify documentation considerations for the Emergency Medical Technician-Basic**

OVERVIEW

- Minimum Data Set
- Prehospital Care Report
- Documentation of Patient Refusal
- Special Situations / Reports / Incident Reporting

Minimum Data Set

- **Patient Information gathered by EMT-B**
  - **On arrival**
  - **Following intervention**
  - **On arrival at facility**



Minimum Data Set (cont)

- **Patient Information**
  - **Chief complaint**
  - **Level of consciousness (AVPU) - mental status**
  - **Systolic blood pressure if > 3 years old**
  - **Skin perfusion (capillary refill) if < 6 years old**
  - **Skin color and temperature**
  - **Pulse rate**
  - **Respiratory rate and effort**

Minimum Dataset (cont)

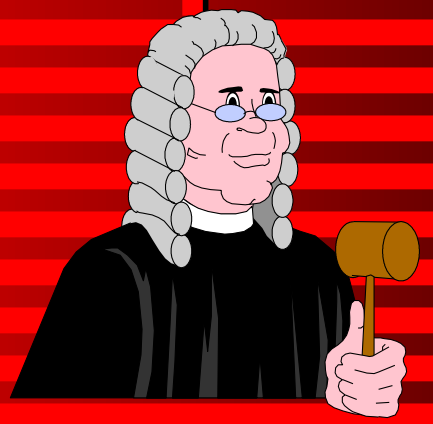
ADMINISTRATIVE DATA

- Time incident reported
- Time unit notified
- Time of arrival at patient

- Time unit left scene
- Time of arrival at destination
- Time of transfer of care
- Accurate / synchronous clocks

Prehospital Care Report

- **Functions**
  - **Continuity of Care**
  - **Legal document**
    - **Medical care provided; status of patient and changes**
    - **Author of information may be summoned to court**
    - **Objective and subjective CLEAR information**

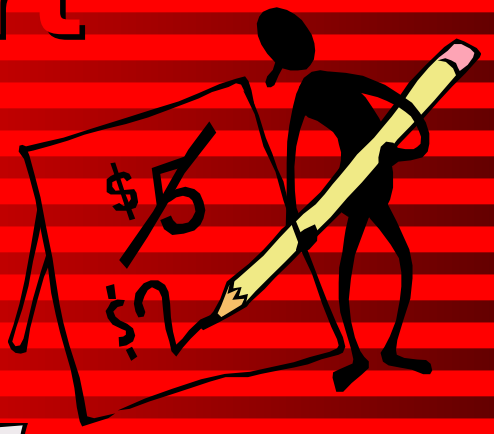


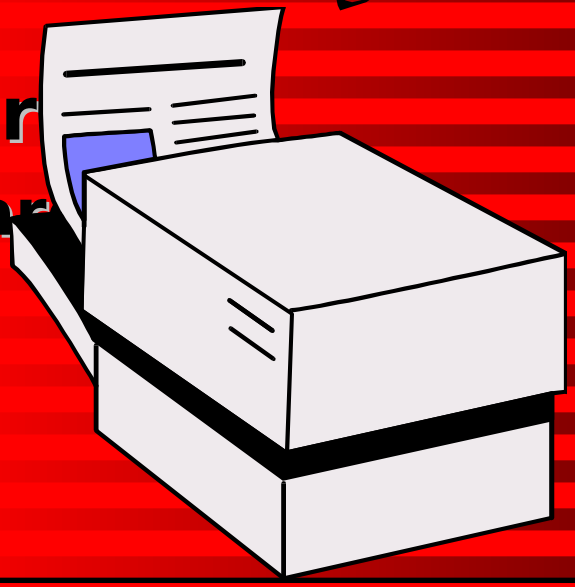
Functions of Prehospital Care Report (cont)

- Educational
- Administrative
  - Billing
  - Service statistics
- Research
- Continuous quality improvement

Using the Prehospital Care Report

- Types
  - Written form
    - Check boxes
    - Narrative section
  - Computerized ver
    - Electronic clipboar
    - Similar device





Using the Prehospital Care Report (cont)

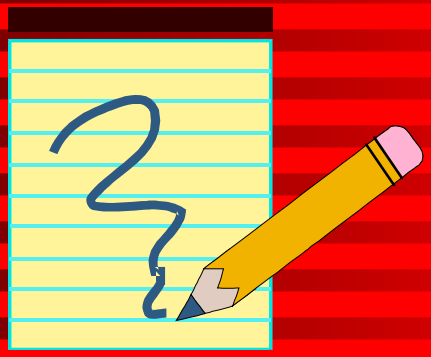
SECTIONS

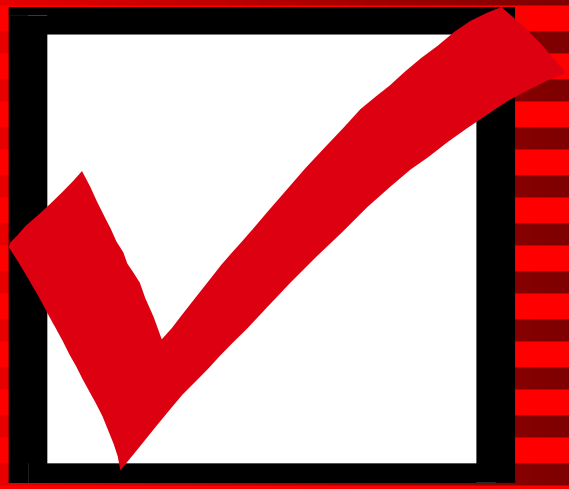
- Run Data
  - Date
  - Times
  - Service
  - Unit
  - Names of crew

- Patient Data
  - Patient information
  - Insurance Information
  - Nature of call
  - Mechanism of injury
  - Treatment
  - Signs/Symptoms
  - Baseline vitals
  - SAMPLE and changes

Using the Prehospital Care Report (cont)

- **Check Boxes**
  - **Be sure to fill the box completely**
  - **Avoid stray marks**





Using the Prehospital Care Report (cont)

- **Narrative Section (if applicable)**
  - **Describe, don't conclude**
  - **Include pertinent negatives**
  - **Scene observations**
  - **Avoid radio codes**

Using the Prehospital Care Report (cont)

- Narrative section (cont)
  - Standard abbreviations
  - Source of sensitive information
  - State reporting requirements
  - Spelling
  - For every reassessment, record time & findings
- Other state or local requirements

Using the Prehospital Care Report (cont)

- **Confidentiality**
- **Distribution - determined by local and state protocol**

Prehospital Care Report

FALSIFICATION ISSUES

- Do not cover up errors of omission or commission. Document what did or did not happen.
- Falsification can lead to poor patient care as well as disciplinary actions
- Difficult areas
  - Vital signs
  - Treatment

Documentation of Patient Refusal

- Competent adults have the right to refuse treatment
- Before leaving, the EMT-B should:
  - Try to persuade patient to go to hospital
  - Ensure patient is able to make rational decision
  - Inform patient
    - Why he/she should go to the hospital
    - What could happen if not

Documentation of Patient Refusal (cont)

- Before leaving, the EMT-B should: (cont)
  - Consult medical direction
  - If patient still refuses, document:
    - Assessment findings
    - Emergency medical care given
    - Have patient sign refusal form

  Have a witness sign the form; especially if patient also refuses to sign the form

Documentation of Patient Refusal (cont)

- **Before leaving, the EMT-B should: (cont)**
  - **Complete the prehospital care report**
    - **Patient Assessment**
    - **Care EMT-B wished to provide**
    - **Statement the EMT-B explained consequences to patient**
    - **Offer alternative methods of gaining care**
    - **State willingness to return**

Special Situations / Reporting Incident Reporting

- Correction of Errors
- Multiple Casualty Incidents (MCI)
- Special Situation Reports
- Continuous Quality Improvement
- Other Uses of Information on Reports

Correction of Errors

- **Discovered while report is being written**
  - **Single horizontal line through error**
  - **Initial and write correct information next to it**
  - **Do not try to erase or obliterate - this could appear as an attempt to cover up a mistake**

Correction of Errors (cont)

- **Discovered after report is submitted**
  - **Using different colored ink, draw single line through error**
  - **Initial and date**
  - **Add note with correct information**
  - **If information was omitted, add not with correct information, including initials and date**

Multiple Casualty Incident

- Might have to fill out report later
- Temporary recording; e.g., triage tags
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  col

Special Situation Reports

- Document events to be reported to local authorities
- Should be timely accurate & objective
- EMT-B should keep copy for his/her records
- Local protocol for submission of report
- Exposure
- Injury

Special Situations / Reportable Incident Report (cont)

- Continuous quality improvement
- Information used to analyze various aspect of the EMS system
- Information used to improve system and prevent problems

SUMMARY

- Minimum Data Set
- Prehospital Care Report
- Documentation of Patient Refusal
- Special Situations / Reports / Incident Reporting

QUESTIONS?